Mississippi State Department of Health

Birth Defects Registry Reporting Form
Genetics Services
Post Office Box 1700
Jackson, MS 39215-1700
Phone: 601-576-7619

The physician must report every birth defect case the first time the patient is seen, for individuals born on or after January 1, 2000. A reporting form is required when reporting a suspected or diagnosed birth defect. If the patient is seen for another birth defect on another occasion, that defect shall also be reported.

1. Patient's Information

Patient's name: _____ _____ _____ _____ _____/_____/_____
Last First MI Suffix Date of Birth

Sex: ___ Male ___ Female **Race:** ___ American Indian ___ Asian ___ Black ___ Hispanic ___ White ___ Other _____
Specify

Admission date: _____ **Discharge date:** _____ **Medical Record #:** _____

Mississippi Resident at Birth: _____ Yes _____ No

2. Birth Information (If Known)

Delivery status: ___ Fetal Death ____ Induced Term ____ Live Birth ____ Stillborn

Birth Multiplicity: ___ Single ___ Twin ___ More than two **Birth Weight** _____
Grams

Birth Facility: _____

Current Medical Provider: _____

3. Birth Mother (or Other Responsible Party if Mother Unknown)

Name: _____ _____ _____ _____
First Middle Last Relationship to patient

Address: _____

City, State, Zip: _____ **County:** _____

Date of Birth: _____/_____/_____

Caregiver Name: _____ _____ _____
(If different from above) First Middle Last

4. Diagnosis (ICD 9/ICD 10 and brief description)

5. Contact Information

Hospital: _____

Reporting Physician: _____

Date reported: _____

Submitter's name: _____

Submitter's phone #: _____
Hospital staff to contact if additional information is needed

Additional information

6. Death Information (If applicable)

Death Date: _____/_____/_____

MSDH Genetics Services use only

Received date: ____/____/____
Entered into BDRS: ____/____/____
By: _____
District: _____

Confidential Information